CHANGE OF ADDRESS / NAME

TO: PAYROLL / PERSONNEL

EFFECTIVE DATE: _____

DEPARTMENT: _____

NAME: _____

ADDRESS: _____

_____

HOME PHONE NUMBER: _____

SOCIAL SECURITY #: _____

SIGNATURE: _____

NOTE: (REGULAR EMPLOYEES ONLY)
PLEASE FILL OUT A RETIREMENT FORM AND IF APPLICABLE A CHANGE OF ADDRESS FORM FOR THE DEFERRED COMPENSATION PLAN.

WHITE: PAYROLL **PINK: PERSONNEL** REV. 01/08

Sacramento County Employees' Retirement System
980 9th Street, Suite 1900
Sacramento, CA 95814
Phone: (916) 874-9119
Fax: (916) 874-6060
Web: www.scers.org

MEMBER'S AFFIDAVIT – FORM 6019

[ ] ACTIVE MEMBER [ ] DEFERRED MEMBER [ ] RETIRED MEMBER [ ] OTHER_____

I. NAME & SOCIAL SECURITY NUMBER √ Change of Existing Information [ ]

First, Middle & Last Name | SSN:

II. PERSONAL INFORMATION √ Change of Existing Information [ ]

Mailing Address: City ST ZIP

Home Address: (If different from Mailing address) City ST ZIP

Telephone Number: ( )_____ Birth Date: Month _____ Day _____ Year_____

III. PERSONAL STATUS √ Change of Existing Information [ ]

[ ]Single [ ] Married [ ] Registered Domestic Partner
[ ] Widowed [ ] Divorced [ ] De-Registered Domestic Partner

IV. BENEFICIARY DESIGNATION(S) √ Change of Existing Information [ ]

	Beneficiary 1		Beneficiary 2		Beneficiary 3	
First Name						
Last Name						
Street Address						
City/State/ZIP						
SSN						
Birth Date						
Relationship & Percentage		%		%		%

[ ] Check if additional beneficiary and/or guardian information is provided in an attachment.

V. PRIOR MEMBERSHIP IN OTHER PUBLIC RETIREMENT SYSTEM(S)

Public Retirement System		Dates of Membership	Status with last public last retirement system.		
SCERS	[ ]		Active [ ]	Misc. [ ]	Tier 1 [ ]
CalPERS	[ ]		Deferred [ ]	Safety [ ]	Tier 2 [ ]
STRS	[ ]		Retired [ ]		Tier 3 [ ]
Other	[ ]		Withdrawn [ ]		

VI. MEMBER DECLARATION OR REQUIRED CONSENT

Section 31760.3 of the Government Code requires the Sacramento County Employees' Retirement System (hereinafter "Plan") to notify your current spouse or registered domestic partner if you change your beneficiary, request a refund of accumulated contributions, or elect an optional settlement of retirement benefits. With limited exceptions, **the Plan cannot allow the designation of an alternate beneficiary without the approval of the current spouse or registered domestic partner.**

A. MEMBER DECLARATION [Read declaration and initial one item, unless Required Consent applies.]

By affixing my initials to one of the statements offered below, I declare that I have accurately reported my marital or partnership status as of the date indicated on this Member's Affidavit and do so under penalty of perjury.

____ I am single, widowed, divorced or de-registered, and I am unaware of any undisclosed actions, agreements or stipulations regarding my Plan benefits.

____ I am married or registered as a domestic partner and I have named my spouse or registered domestic partner as sole beneficiary under the Plan. Beyond the interests of my current spouse or registered domestic partner, I am unaware of any undisclosed actions, agreements or stipulations regarding my Plan benefits.

B. REQUIRED CONSENT - CURRENT SPOUSE OR REGISTERED DOMESTIC PARTNER AGREEMENT TO ALTERNATE BENEFICIARY

I acknowledge and agree with the BENEFICIARY DESIGNATION(S) elected by my spouse or registered domestic partner, and I understand that my consent to this item is voluntary. Absent a Court order to the contrary, I also understand that (a) the beneficiary change requested by my spouse or registered domestic partner is not effective without my signature, (b) future beneficiary changes by my spouse or registered domestic partner still require my signature and consent, and (c) the effect of my signature and consent may be to forfeit benefits to which I would otherwise be entitled upon the death of my spouse or registered domestic partner.

_____ _____

Spouse or Registered Domestic Partner Signature Date

REQUIRED VERIFICATION OF SPOUSE OR REGISTERED DOMESTIC PARTNER SIGNATURE

Option i: Witnessed by Plan Representative

Signature witnessed this _____ day of _____, 20 _____.

Plan Representative: _____

Option ii: Witnessed by Notary Public

BEFORE ME, the undersigned, a Notary Public, personally appeared _____ who executed the above Required Consent as a free and voluntary act.

(SEAL) Notary Public: _____

My Commission Expires: _____

VII. MEMBER APPROVAL OF REQUESTED CHANGES AND/OR ADDITIONS

I understand in the event of my death before retirement, my surviving spouse and/or minor children may have superior rights to benefits pursuant to provisions of the County Employees' Retirement Law of 1937, regardless of whether I named the spouse and/or minor children as beneficiary(ies) of any benefits payable on or by reason of the member's death. I declare under penalty of perjury, that the foregoing statements are full, true and correct.

X _____

Member Signature & Print Name **Date**

Internal Services Agency
Department of Personnel Services
Employee Benefits Office

Terry Schutten, County Executive
Mark Norris, Agency Administrator
David Devine, Department Director

County of Sacramento

CHANGE FORM

☐ Name Change ☐ Address Change

Employee Name: _____

SSN: _____ DOB: _____

Current Address: _____

City: _____ State: _____ Zip Code: _____

Work Number: _____

Home Number: _____

Health Plan: _____

Signature: _____ Date: _____

Please Return To:

Employee Benefits Office

700 H Street, Room 6750

Sacramento, CA 95814

Mail Code: 09-6750
Fax Number: 874-4621

ICMARC
Building Retirement Security

VANTAGECARE RETIREMENT HEALTH SAVINGS (RHS) PLAN
EMPLOYEE ENROLLMENT/CHANGE FORM - Page 1

- Use this form to enroll in the RHS Plan or to make any changes to your existing RHS Plan account.
- Read the instructions on the back before completing the form. Please use blue or black ink.
- Please check all applicable boxes:

☐ New Enrollment

Type of Change:

☐ Change in Name (Please attach legal document)
☐ Change in Address
☐ Change in Marital Status
☐ Change in Work Information
☐ Change in Survivor

1 Essential Information

Employer Plan Number 8 ___ ___ ___ ___ ___

Employer Name _____

State _____

Participant Name (Last, First and Middle Initial) _____

Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

2 Participant Personal Information

Mailing Address

Street _____

City _____

State _____ Zip Code _____

Evening Phone Number
(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___
Area Code

Email Address _____

Gender
☐ Female ☐ Male

Marital Status
☐ Married ☐ Single

Date of Birth
___ ___ / ___ ___ / ___ ___ ___ ___
Month Day Year

Date Employed
___ ___ / ___ ___ / ___ ___ ___ ___
Month Day Year

3 Work Information

Job Title _____

Daytime Phone Number
(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___
Area Code

4 Survivor Information (Note: Please read the instructions.)

Survivors

Spouse Name _____ SSN ___ - ___ - ___ Date of Birth _____

Dependent Name _____ SSN ___ - ___ - ___ Date of Birth _____

Dependent Name _____ SSN ___ - ___ - ___ Date of Birth _____

Dependent Name _____ SSN ___ - ___ - ___ Date of Birth _____

Dependent Name _____ SSN ___ - ___ - ___ Date of Birth _____

☐ Additional survivor information on attached sheet

PLEASE RETAIN A COPY FOR YOUR RECORDS AND RETURN THE ORIGINAL TO YOUR EMPLOYER

(continued on back)

ICMARC
Building Retirement Security

VANTAGECARE RETIREMENT HEALTH SAVINGS (RHS) PLAN
EMPLOYEE ENROLLMENT/CHANGE FORM - Page 2

5 Authorized Signatures

For new enrollments:

- I acknowledge that I have received and read the current Vantagepoint Funds Prospectus prior to investing in any funds.
- I understand that I will not be permitted to choose to cease participation so long as I am a member of the covered group.

For all enrollments and changes:

- I acknowledge that I have read the instructions for the RHS Plan Employee Enrollment/ Change Form. I understand that the ICMA Retirement Corporation has established required procedures for telephone and Internet transfers that include personal identification numbers, recorded instructions, and written confirmations. In the event I choose to transfer funds by telephone or Internet, I agree that neither the ICMA Retirement Corporation, nor ICMA-RC Services, LLC, will be liable for any loss, cost, or expense for acting upon any telephone or Internet instructions believed by it to be genuine and in accordance with the required procedures.
- If applicable, I understand that the availability of benefits for domestic partners, same sex spouses, and civil unions varies by state and that the tax treatment of RHS reimbursements in these situations may also vary.
- I understand that upon my death, my account will be transferred to my spouse and/or other qualifying dependents for tax-free reimbursement of qualifying medical expenses. If I am not survived by a spouse or any dependents, my account balance will return to my employer's RHS trust.

Participant Signature _____ Date _____

6 Employer Use Only

Employer Signature _____ Date _____

Is the employee currently eligible to receive benefits from the RHS Account under Section IX of your RHS Plan Adoption Agreement? ☐ Yes* ☐ No

If yes, what date did the employee become eligible? ___ ___/___ ___/___ ___ ___ ___
Month Day Year

☐ Eligibility date entered in EZLink (see Chapter 4 of the RHS Plan Employer Manual).

*** If yes, the Participant should also complete the *RHS Plan Employee Eligibility Form* for Meritain Health, Inc.**